Statewide Suicide Prevention Plan

Montana Strategic Suicide Prevention Plan

The Montana Department of Public Health and Human Services
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SUICIDE PREVENTION IN MONTANA: AN ON-GOING PLAN

Introduction

Wanting to die and feeling suicidal is a primary symptom of an untreated brain disorder, a medical condition for which treatment is available.

Brain disorders or mental illness are a physical illness, not a character flaw or weakness.[6]

Suicide persists as major public health problems in Montana.[1] There are many individuals and organizations that are working to address this issue. These include: survivors, youth, law enforcement officers, tribal members, mental health professionals, health care providers, community volunteers, schools, not-for-profit agencies, spiritual leaders, clergy, state, local and federal government officials, and many others.

The individuals and agencies that are currently addressing suicide often do so from their own unique perspective and to meet their own special needs in part not collaboratively. Until 2000, there had been no statewide, strategic effort to link these many assets and to build a stronger network of resources to address suicide as a major statewide public health priority.

In the spring of 2000, the Montana Department of Public Health and Human Services invited a group of private organizations, concerned citizens and government officials to begin the development of a statewide plan for suicide prevention. With consultation from international experts in suicide prevention, the Montana Suicide Prevention Steering Committee began works that lead to the development of this statewide strategic plan. This document is the result of the initial planning effort, and originally outlined a 5-year strategic direction and an action plan.

This plan was updated in the spring of 2005 by key stakeholders committed to reducing suicide in Montana. Accomplishments and ongoing challenges were delineated. Strategic directions for prevention, intervention, postvention and coordination among providers were expanded.

Update and Accomplishments to Date

Since the inception of the Montana Suicide Prevention Plan in 2001, Montana has made progress toward several goals pertaining to suicide prevention. Namely, progress has taken place in suicide prevention training, increased knowledge and awareness about the problem of suicide and mental illness, expansion of provider networks and systems of care, and state funding was provided to several communities for suicide prevention projects.

1. The Stakeholders have conducted suicide prevention and awareness training via several venues
    - Nationally recognized QPR (Question, Persuade, Refer) training program was used to train gatekeepers in a number of Montana cities and communities,
    - QPR training for law enforcement personnel in some areas of the State
    - Suicide Survivor Support Facilitators trainings – up to 15 people have trained to facilitate healing for suicide survivors

2. Progress toward improving public awareness of the issue of suicide and mental illness through the following partnerships:
    - The Montana Mental Health Association's Public Awareness Campaign, including training in the SOS protocol for Montana high schools.
    - The Montana Chapter of the American Foundation for Suicide Prevention's outreach program which includes:
        - Certified QPR Instructor Training,
        - QPR Gatekeeper Training and Community Outreach,
        - Community-based Suicide Prevention Groups,
        - AFSP Survivor Support Group Facilitator Training,
        - AFSP Survivors of Suicide Day Teleconference,
        - Community Mental Health Services Resource Banks,
        - AFSP 'Out of the Darkness' Community Walk
3. Montana has begun to address the lack of crisis response services across the state. Two community pilot programs and the recent legislature have formed an interim study group to look at this issue.
    - Several agency websites now prominently address the issue of suicide and link to the national Suicide Prevention Resource Center.
4. Increased capacity from the collaboration and formation of provider networks
    - A Crisis line for suicidal individuals, Voice of Hope based in Great Falls, has been accredited by the American Association of Suicidology and is now part of the National Suicide Prevention Lifeline (1-800-273-TALK)
    - Community coalitions addressing suicide have been formed in local communities across the state
    - A Native American Teen Suicide Prevention training curriculum has been implemented
    - Kids Management Authorities (KMA) has been established in each of the five children's Mental Health management regions. KMA's are charged to identify issues and solutions, and facilitate coordination of multiple agencies resources to improve mental health for kids.
    - Local Advisory Councils were created for oversight of adult mental health care.
5. In addition, there have been several grants obtained to help improve and/or understand the issue of suicide in Montana.
    - The Governor's Initiative provided funding for several local suicide prevention networks, including one tribal initiative and three local community prevention projects.
    - A Systems of Care Grant

- A grant to the Voices of Hope to provide training and library services to increase the competency of mental health and social service providers
- Fetal, Infant, Child Mortality Review Grant
- Early Childhood Comprehensive Systems Grant

Challenges

Though we have made progress since the initiation of the Suicide Prevention Plan, Montanans are still faced with many challenges. Montana's suicide rate remains among the highest in the Nation. Suicide is the second leading cause of death for adolescents and young adults in our state.[1] We have identified many areas where improvements can be made.

Suicide is the most preventable form of death in America. The vast majority of all suicidal people want to live, if only they can be shown the way.

Research shows the great majority of those who attempt suicide give some warning signs, verbal or behavioral, of their intent to kill themselves, often during the week preceding a suicide attempt.[4]

Lack of statewide coordination

- Systems collaboration between tribal entities, counties and state government, especially for adolescent and young adult populations are inadequate.
- Coordination between community levels and state systems is inadequate. Local communities may not know about initiatives in other parts of the state or in state government. State government agencies are often not aware of prevention efforts related to suicide in other agencies.
- Development of suicide prevention strategies often occurs without the involvement of youth in the planning process.
- Screening for mental illness and suicide does not consistently occur in public schools, juvenile justice systems, or other child-serving agencies. Screening is inconsistent in the medical community

Montana demographics and geography

- Montana is a large frontier state with many isolated communities
- Ongoing stigma towards seeking mental health services and concerns of maintaining confidentiality in small communities inhibit individuals from seeking needed treatment[4]
- A large percentage of Montana's population lacks health coverage[11]
- Montana has a high availability of lethal means, especially firearms, that increase the lethality of impulsive suicidal behaviors[1]
- Montana has high rates of alcoholism and other drug addictions; including the current devastating epidemic of Methamphetamine use
- Montana has high rates of sexual and physical abuse as well as domestic violence affecting both children and adults

- The farm and ranch economic crisis and the difficulty in attracting industry to provide a stable employment market in Montana are ongoing stressors.

Lack of mental health providers and treatment facilities

- There is a shortage of inpatient mental health treatment facilities. The availability of this vital resource is diminishing with the closure of inpatient psychiatric beds.
- There is a severe lack of appropriate comprehensive outpatient services.
- There is insufficient integration of traditional and culturally specific interventions
- Montana has a severe shortage of psychiatrists, especially child and adolescent psychiatrists
- There is a lack of physicians capable of providing appropriate psychiatric medication treatments
- There is a lack of postvention services

Suicide – The Magnitude of the Problem

United States

Overall, suicide rates have remained fairly stable over the last 20 years. However, increases in the rates of suicide among certain age, gender, and ethnic groups have changed. Suicide rates among adolescents and youth in some areas of the nation have increased dramatically. At the other end of the age spectrum, suicide rates remain the highest among white males over the age of 65. Differences are also occurring in some racial groups with the rates of suicide among young African American males showing significant increases.

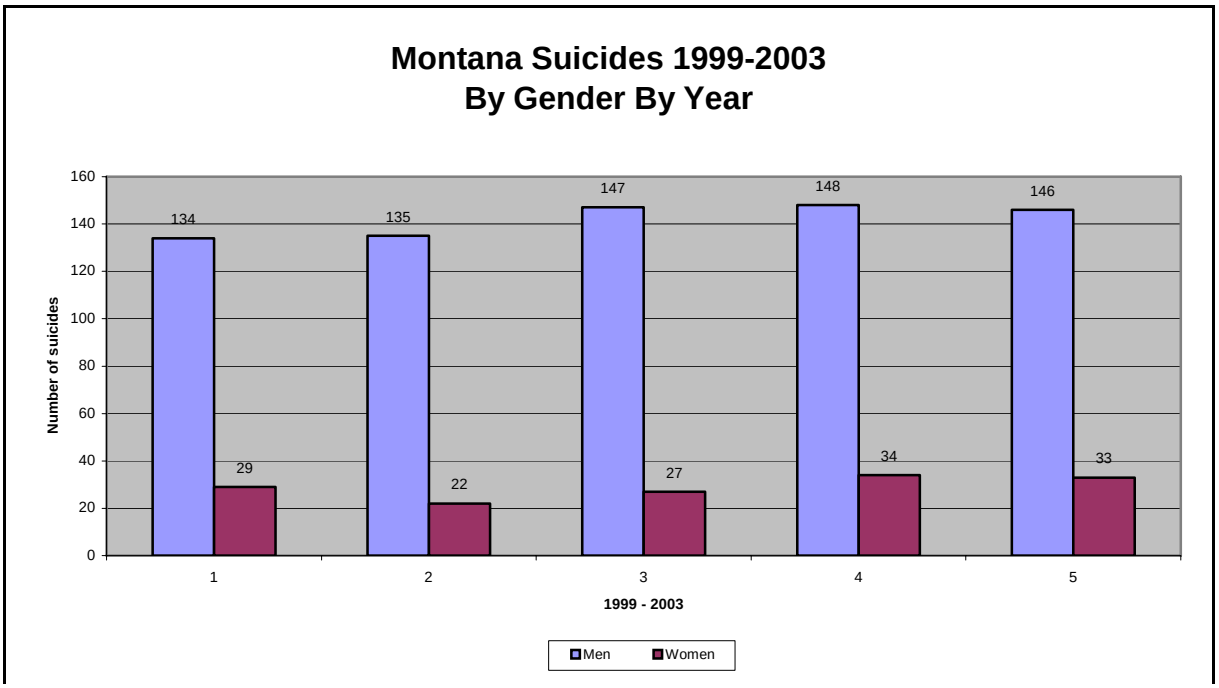
Suicide is a serious complex issue. In 1998, suicide was the 8th leading cause of death in the United States accounting for nearly 31,000 deaths. This number is 50% higher than the number of homicides during that same year. [2]

Approximately 500,000 people a year in the United States require emergency room treatment as a result of a suicide attempt.[3] Suicide has a devastating and, often lasting, impact on those that have lost a loved one as a result of suicide. While suicide rates in the U.S. place it near the mean for industrialized nations, the rates within the U.S. are highly variable by region and state.[4] The intermountain western states have the highest rates of suicide as a region and Montana ranks persistently at the top of the rate chart annually.[1]

Montana

Unfortunately, Montana has ranked among the top 5 states with the highest rates of suicide for the past 20 years, along with other mountain states. For a number of years, Montana has been number two on the yearly charts second only to Nevada. This is not a new trend. It dates back to the earliest recorded data concerning suicide in the U.S.[4] Suicide in Montana is a serious public health crisis. The following graphs illustrate the prevalence of suicide in Montana across gender, race and age from 1999 to 2003.[1]

Figure 1



Gender

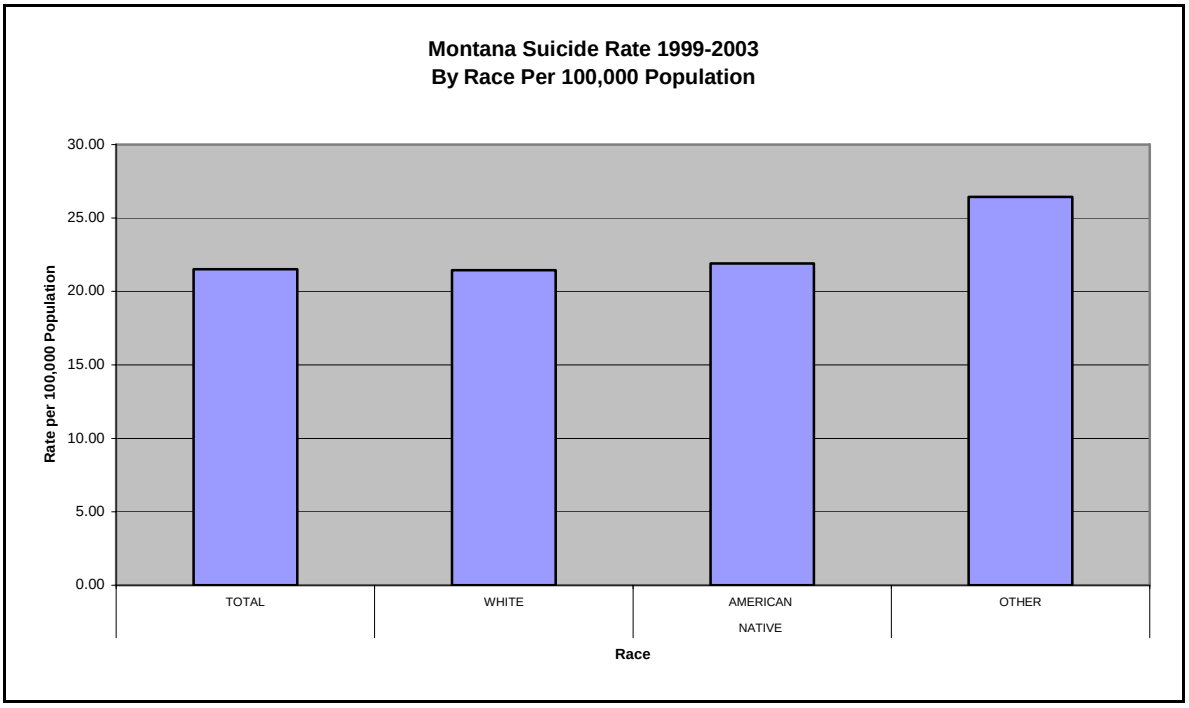
Montana is consistent with the rest of the U.S. in that suicide deaths vary by gender with males at greater risk than females. Montana females are five times more likely than males to attempt suicide. More females choose *reversible* means such as poison; more males choose *irreversible* means such as fire arms. Figure 1 documents the differences in risk of suicide by gender.

Race

Suicide in Montana also varies, to some degree, by race. The small population of American Indian[±] residents in Montana results in highly variable rates by year. A small increase in the actual numbers of deaths can have, what appears to be, a catastrophic impact on the rate for that year. Taking into account this rate variability due to small populations, the difference in rates between American Indians and Caucasians in Montana is minimal when considered over time. Both rates are much too high. Figure 2 documents the similarities in rates by race.[1]

[±] The term American Indian is used throughout this document with the greatest respect for the indigenous people of Montana. We acknowledge that some nations, bands, tribes, clans and individuals prefer other nomenclature including Native Americans, First Nations and indigenous people. The term American Indian was selected based upon the majority input received by Native representatives on the steering committee and is used exclusively throughout the document to provide continuity.

Figure 2



While Figure 2 does not break down the American Indian population into the various subdivisions of nations, tribes, bands and clans, for any given time period there is a high degree of variability among these classifications, just as there is similar variability among the Caucasian population when stratified by counties, cities and towns. What is clear from Figure 2 is that it is important to track the rates of suicide over time since any one year period may demonstrate marked deviation from the mean.

Specific cultural factors for Native American communities contribute to the suicide rates for this population. These include high unemployment rates, alienation and varying cultural views on suicide.

Age

Suicide rates in Montana vary widely by age. When all ages are combined, suicide is ranked the 9th leading cause of deaths for Montanans for more than two decades. However, when those rankings are examined by age group the risk of suicide varies considerably.

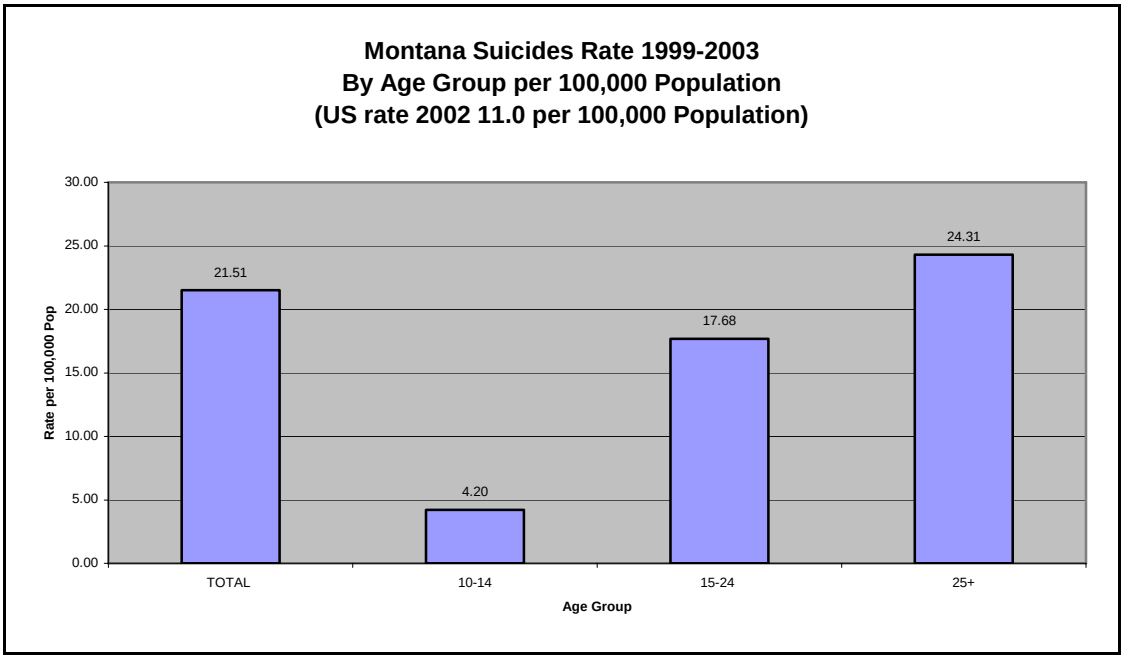
Montana's youth suicide rate is *higher* than the National youth suicide average.[1]

Death by suicide is significant cause of mortality among youth and young adults in Montana. It is the leading cause of preventable death for the ages 10 to 14 and the second leading cause of death for the ages 15 to 24 and 25 to 34.[1]

There are many aspects to the adolescent developmental stages that heighten suicide risk. One of the most significant is the importance of peer relationships and the need to "fit in" which can put pressure on adolescents to not disclose suicidal feelings. In addition, there is a "conspiracy of silence" among adolescents to not disclose to adults when a friend expresses suicidal ideation. Fragmented families, drug and alcohol use, sexual identity questions, bullying, and the negative influences of popular media also contribute to the increased risk of suicide in adolescents and young adults.

Other risk factors include a previous suicide attempt, mental disorders—particularly mood disorders such as depression and bipolar disorder; co-occurring mental and alcohol and substance abuse disorders; a family history of suicide; hopelessness; impulsive and/or aggressive tendencies; barriers to accessing mental health treatment; relational, social, work, or financial loss; easy access to lethal methods, especially guns; unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts; influence of significant people—family members, celebrities, peers who have died by suicide—both through direct personal contact or inappropriate media representations; cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma; and isolation, a feeling of being cut off from other people.[5]

Figure 3



Compared nationally, Montana's rate of suicide from 1999 – 2003 for 15 – 24 year olds was 17.68 per 100,000 while nationally is was to 10.01 per 100,000.

In Table 1 the magnitude of the threat from suicide for adolescents and young adults, as well as older Montanans becomes readily apparent. What is truly disturbing is that for Montana's children and teens suicide is among the leading causes of death.

Table 1

10 Leading Causes of Death, Montana 2002, All Races, Both Sexes

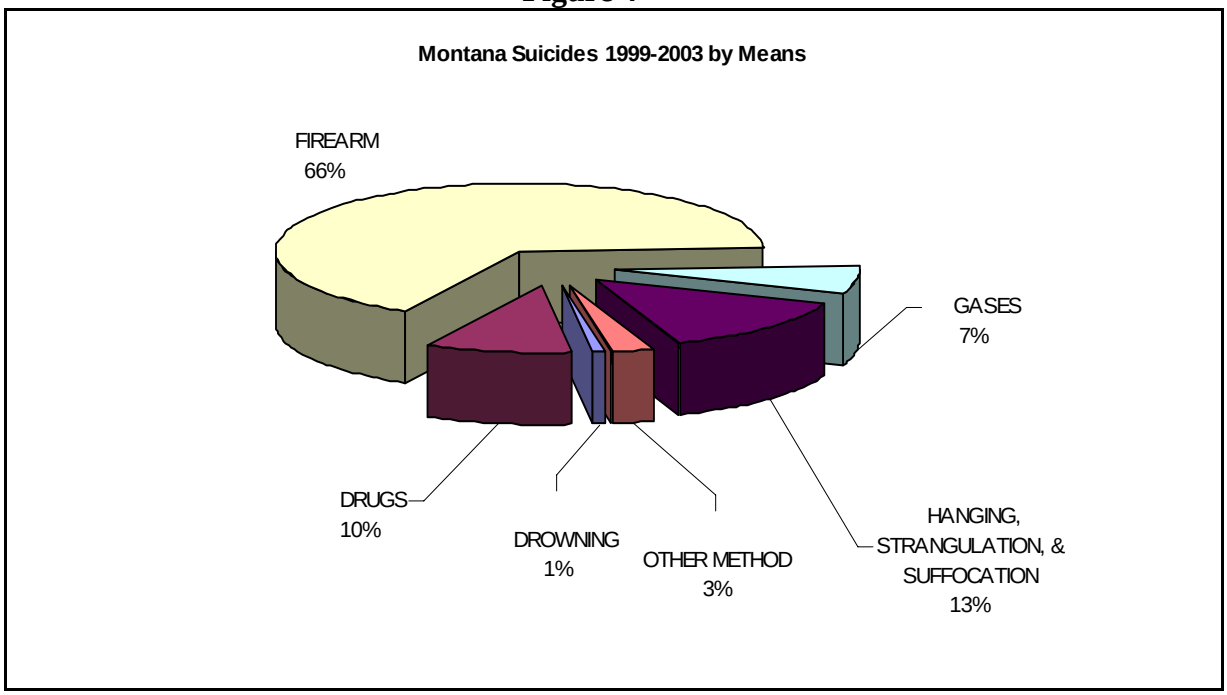
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury	Malignant Neoplasms	Malignant Neoplasms	Heart Disease	Heart Disease
2	SIDS	Congenital Anomalies	Malignant Neoplasms	Homicide	Suicide	Suicide	Malignant Neoplasms	Heart Disease	Heart Disease	Malignant Neoplasms	Malignant Neoplasms
3	Short Gestation	Heart Disease	Homicide	Congenital Anomalies	Malignant Neoplasms	Malignant Neoplasms	Suicide	Unintentional Injury	Chronic Low. Respiratory Disease	Cerebro-vascular	Cerebro-vascular
4	Maternal Pregnancy Comp.	Acute Bronchitis		Influenza & Pneumonia	Homicide	Liver Disease	Heart Disease	Liver Disease	Unintentional Injury	Chronic Low. Respiratory Disease	Chronic Low. Respiratory Disease
5	Placenta Cord Membranes	Homicide		Suicide	Heart Disease	Heart Disease	Liver Disease	Suicide	Cerebro-vascular	Alzheimer's Disease	Unintentional Injury
6	Circulatory System Disease	Malignant Neoplasms			Congenital Anomalies	Homicide	Diabetes Mellitus	Diabetes Mellitus	Liver Disease	Influenza & Pneumonia	Alzheimer's Disease
7	Birth Trauma	Septicemia			Diabetes Mellitus	Congenital Anomalies	Influenza & Pneumonia	Cerebro-vascular	Suicide	Unintentional Injury	Influenza & Pneumonia
8	Ten Tied					Diabetes Mellitus	HIV	Influenza & Pneumonia	Diabetes Mellitus	Diabetes Mellitus	Diabetes Mellitus
9	Ten Tied					Five Tied	Homicide	Chronic Low. Respiratory Disease	Influenza & Pneumonia	Nephritis	Suicide
10	Ten Tied					Five Tied	Septicemia	Septicemia	Septicemia	Pneumonitis	Liver Disease

Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC Data Source: National Center for Health Statistics (NCHS) Vital Statistics

Lethal Means

A number of means are used in the act of suicide in Montana. Of these, firearms and hanging are the most common. Other lethal means include: carbon monoxide, overdose, motor vehicle crashes, jumping from heights, etc. Figure 4 verifies the preponderance of firearms and hanging in Montana suicides.[1]

Figure 4



Opportunities for Prevention Activities

The variations in suicide rates by age groups and gender provide a wide array of opportunities for prevention and intervention activities. Prevention strategies can cover a wide variety of target groups (e.g., population at large, those who have ever thought of suicide as an option, those who have made previous attempts at suicide, and those in immediate crisis who are contemplating suicide as well as those who have experienced the death of a family member or close friend). Such activities can also range from a broad focus such as addressing risk and protective factors to a more narrow focus such as preventing imminent self-harm or death. Although the data on effectiveness of various programs and interventions is limited, certain strategies are beginning to emerge as more effective than others.[6] Clearly, a singularly focused intervention strategy such as a crisis line or gatekeeper training program will not have a lasting impact in isolation. Each program needs to be tightly integrated and interlinked with other strategies to reach the broadest possible range of persons at risk.

The following activities are recommended for the various demographic groups:

Youth – Ages 15 - 21

Although males are more at risk of dying from suicide, females make more attempts. Among the leading causes of hospital admission for women in this age group are poison-related suicide attempts.

Possible measures for this group include:

- Home visitation to high risk young families by Public Health personnel,
- Therapeutic Foster Care for high needs youth to provide a safe environment in which "wrap around" services could be provided,
- Inclusive, drug free, violence free, after school activity programs ran between 3pm – 8pm; offering a wide array of activities including the arts, volunteer opportunities and sports which will appeal to youths of varied backgrounds. These programs need to provide adult supervision by both qualified staff and volunteers and provide a forum for community resiliency and mentoring,
- School-based mentoring programs provided by older students and/or adults for at-risk youth as well as students transitioning to high school,
- Gate Keeper/QPR training for adults who work with youth to reduce stigma around suicide and raise awareness of risk factors and provide referral information,
- Although a recent review of firearm restriction laws by a group of CDC researchers rated them "insufficient evidence to determine effectiveness," Grossman and others from Harborview Center, Seattle have indicated lock boxes, gun locks and storing firearms and ammunition separately has some efficacy in terms of restricting lethal means. Restricting lethal means has reduced suicides in Australia markedly over the last 30 years. Advocating for safe gun storage and also gun removal away from the home in the case of unstable or depressed youth may result in reduced suicides,
- Reducing illegal drugs (methamphetamine, marijuana, etc.), alcohol and lethal prescription drugs would decrease the impact of this risk factor for suicide,
- Continue development of youth areas of our www.montanasuicide.org website based at CIT; youth are likely to go to websites before using a crisis telephone line, and
- Enhance protective factors and provide coping skills for youth in all arenas of life.
- There is a correlation between smoking and suicidal behavior in people of all ages. The Journal of Adolescent Medicine (2004) reported that teenagers who smoke had a rate of suicide attempts four times higher than teens who do not.

Older Adults – Ages 20 - 44

This group represents the biggest actual number of suicides in Montana; most suicides in this group are male and completed with use of a gun. Interventions for this group are especially difficult.

- There is evidence that having physicians receive gate keeper training subsequently assessing all patients for depression and suicide risk factors and making appropriate and timely referrals for mental health services could have positive effects with this group,
- There is a correlation between smoking and suicidal behavior in people of all ages.
- Crisis lines - in survey data from Australia, fully 40% of callers felt the crisis line saved them. However, not many men use crisis lines. We need to continue improving our statewide crisis line options with campaigns to reduce "use stigma," and
- Development of lay provider crisis intervention teams, creating more hospital beds designated for mental health, and suicide stigma reduction campaigns would increase intervention possibilities for suicidal individuals.

Senior Caucasian Males, Over Age 55

This group has one of the highest rates of suicide within Montana demographics. Rural isolation, lack of access to mental health resources and access to lethal means are major risk factors with this age group.

- The development of lay provider calling trees set up among senior volunteer groups to reduce isolation establishing gate keeper type interventions among this group would be beneficial in reducing suicide risk,
- The medical community serving this population could be trained in gatekeeper training and universally screen patients for depression, mental illness and or drug/alcohol abuse, and
- Senior suicide is related to severe illness and chronic pain. Improved pain management and increased resiliency among this group could reduce suicide.

Protective Factors

Some individuals and communities are more resistant to suicide than others. Little is known about these protective factors. However they might include genetic and neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes. According to the Surgeon General's Call to Action to Prevent Suicide[6], protective factors include:

- Effective and appropriate clinical care for mental, physical and substance abuse disorders,
- Easy access to a variety of clinical interventions and support for help seeking,
- Restricted access to highly lethal methods of suicide,
- Family and community support,
- Support from ongoing medical and mental health care relationships,
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes, and

- Cultural and religious beliefs that discourage suicide and support self-preservation instincts, including American Indians practice of non-separation of culture, spirituality, and/or religion.

As with prevention and intervention activities, when programs to enhance protective factors are introduced, they must build on individual and community assets. They must also be culturally appropriate. As an example protective factors enhancement in any one of Montana's American Indian communities must capitalize on the native customs and spiritual beliefs of that nation, tribe or band.

The Vision

We value human life. We encourage all people and organizations in Montana to deal openly, collaboratively and with sensitivity for all cultures to minimize suicide. We are working to create an environment where everyone will have access to qualified resources for help when they are in need.

The Mission

There will be a sustained reduction in the incidence, prevalence and rate of suicide and non-lethal suicidal behavior in Montana.

The Goals

To accomplish our mission and move towards the realization of our vision there are several key goals which must be accomplished in Montana.

- To systematically pursue promising and best practices related to prevention, intervention, and postvention strategies to implement statewide,
- To dedicate sufficient personnel and fiscal resources to address the issue of suicide prevention activities in a structured and long-term manner,
- To increase public awareness and concern around the issue of suicide as a leading cause of death and significant public health problem in Montana,
- To strive to develop and implement replicable rural and frontier strategies
- To work together in a collaborative, coordinated manner at the local, regional, tribal and state levels to best implement strategies and practices for suicide prevention.
- To continually assess and evaluate progress towards our mission,

The Environment for Suicide Prevention in Montana

The State Strategic Suicide Prevention Steering Committee has identified factors that could impact the implementation of this plan. These factors include: assets that could have a positive and supportive impact on the implementation of the plan; barriers and challenges to carrying out the plan; and finally, near term opportunities that could be leveraged to aid in the successful implementation of the plan.

Attitudes

A social stigma is attached to suicide that promotes silence, apathy and disinterest in the issues.[4]

- To date there has been a lack of community awareness and acceptance of the problem.
- The debate continues in some groups about whether suicide is an individual or community problem. It is, for some, easier to tackle the "individual" problem (acute care or after the fact intervention) and more difficult to take on the "community problem" (primary prevention and encouraging protective factors).
- There is a lack of cultural awareness and sensitivity by suicide prevention staff and in prevention materials and programs.
- In many communities, there is insufficient expertise and capacity and often they must rely on expertise from outside of the local community to guide plans and activities. This lack of local capacity may result in the purchase of commercial products and programs that are without proven efficacy.
- The actual number of suicides within a given community is low; therefore, the problem is easy to ignore or dismiss.
- Sustaining interest in suicide prevention activities is difficult after a crisis situation or a completed suicide fades into the distant past.
- Changes in leadership often mean changes in public health agendas and priorities.

Montana's Unique Characteristics

- Much of Montana epitomizes geographical isolation, accentuated by the harsh winter climate.
- Since the arrival of the earliest white settlers, there has been an ingrained social culture that has accepted suicide as a part of life in Montana.
- Montana's rate of suicide has proven resistant to improvement from previous prevention efforts.
- There is a lack of availability and access to mental health services in many areas in the state, in part due to the state's remoteness.

Studies suggest there is a correlation between the rates of alcohol consumption and suicide.[7, 8 & 9]

- There is a prevalent and proud "western" culture and attitude among the Caucasian majority in Montana - 'we can take care of ourselves.'
- Frequently, there is access to firearms that are not properly stored.
- There is a lack of transportation services for some people that inhibits their ability to seek or receive help.
- There is a lack of communication infrastructure (phones, cellular service, and Internet access) in some areas, including American Indian reservations, frontier and rural areas.

- Montana ranks high in alcohol and substance abuse when compared to other states in the U.S.

Strategic Directions

Due to the diversity of the State, the Steering Committee considers the most important direction to focus resources and attentions is promoting and working towards implementation of programs specific to communities and/or statewide.

Prevention

- Increase awareness of youth suicide prevention
- Develop community provider networks
- Conduct gatekeeper training
- Provide screening programs

Intervention

- Increase access to mental health and substance abuse services including smoking cessation programs
- Develop and implement clinical screening programs and standard screening tools with appropriate referral and follow-up
- Develop a statewide crisis response system

Postvention

- Reduce access to lethal means with affected circles of suicide survivors
- Improve services for survivors
- Provide support and resources to families of persons at high risk or who have attempted

Coordination

- Improve communication and community linkages with mental health and substance abuse service systems serving youth and young adults
- Designate a state lead
- Demonstrate collaboration

Assuring Support for the Plan

Key personnel, organizations and stakeholders were contacted for their review and comment throughout the process. The steering committee members were encouraged to have their organizations and constituents review and comment on the plan after it was posted on the web site (http://www.montanasuicide.org).

The Montana State Strategic Suicide Prevention Plan was presented to the Montana Public Health Association (MPHA) to keep them apprised of the ongoing efforts to reduce suicide in Montana.

After the final review and approval of the plan by the steering committee, the suicide prevention plan was reviewed and approved by the Montana Department of Public Health and Human Services.

Ongoing presentations of this Suicide Prevention Plan shall take place for mental health providers, advocacy agencies, and other individuals/agencies with concern about Montana's high suicide rates.

Progress Review and Plan Updates

As a way to assess and evaluate progress towards the goals, the Steering Committee will conduct a quarterly plan review and progress update on the plan. These reviews will include data from the various programs activities and practices suggested in the plan implementation strategy and exploration of funding opportunities.

Ongoing Activities

The reader is invited to visit http://www.montanasuicide.org to review ongoing activities, identify resources and explore links to prominent state and national organizations dedicated to addressing the many faces of suicide prevention.

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